		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039818

Facility Name: Jeffersonian Care Center

Address: 1700 White St. (Number) Mt. Vernon (City) 62864 (Zip Code)

County: Jefferson

Telephone Number: (618) 242-4075 **Fax #** (618) 242-4092

IDPA ID Number: 391516877003

Date of Initial License for Current Owners: 10/01/94

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL		
	[X] Charitable Corp.		[ ] Individual		[ ] State		
	[ ] Trust		[ ] Partnership		[ ] County		
IRS Exemption Code	501 (c) (3)		[ ] Corporation		[ ] Other		
			[ ] "Sub-S" Corp.				
			[ ] Limited Liability Co.				
			[ ] Trust				
			[ ] Other				

In the event there are further questions about this report, please contact:
Name: Christine Hanover **Telephone Number:** (312) 384-6000
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/03 to 06/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/03 Ending: 06/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	65	Skilled (SNF)	65	23,790	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	65	TOTALS	65	23,790	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,984	4,917	5,652	19,553	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,984	4,917	5,652	19,553	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.19%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 30 and days of care provided 5,583

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/04 Fiscal Year: 06/30/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/03 Ending: 06/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	104,755	8,192	6,180	119,127		119,127		119,127			1
2	Food Purchase		96,918		96,918		96,918	(18,456)	78,462			2
3	Housekeeping	67,192	10,481		77,673		77,673		77,673			3
4	Laundry	25,112	7,485		32,597		32,597		32,597			4
5	Heat and Other Utilities			65,085	65,085		65,085		65,085			5
6	Maintenance	19,973		22,520	42,493		42,493		42,493			6
7	Other (specify):*											7
8	**TOTAL General Services**	217,032	123,076	93,785	433,893		433,893	(18,456)	415,437			8
	B. Health Care and Programs											
9	Medical Director			6,100	6,100		6,100		6,100			9
10	Nursing and Medical Records	906,896	73,529	2,665	983,090		983,090		983,090			10
10a	Therapy			681,928	681,928		681,928		681,928			10a
11	Activities	21,307	1,977	3,437	26,721		26,721		26,721			11
12	Social Services	20,344	65	2,378	22,787		22,787		22,787			12
13	Nurse Aide Training			1,856	1,856		1,856		1,856			13
14	Program Transportation			879	879		879		879			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	948,547	75,571	699,243	1,723,361		1,723,361		1,723,361			16
	C. General Administration											
17	Administrative	47,333		144,000	191,333		191,333		191,333			17
18	Directors Fees											18
19	Professional Services			3,250	3,250		3,250	10,702	13,952			19
20	Dues, Fees, Subscriptions & Promotions			5,642	5,642		5,642	119	5,761			20
21	Clerical & General Office Expenses	39,589	6,278	23,683	69,550		69,550	2,198	71,748			21
22	Employee Benefits & Payroll Taxes			126,356	126,356		126,356	86,737	213,093			22
23	Inservice Training & Education			759	759		759		759			23
24	Travel and Seminar			6,800	6,800		6,800	119	6,919			24
25	Other Admin. Staff Transportation			544	544		544		544			25
26	Insurance-Prop.Liab.Malpractice							42,891	42,891			26
27	Other (specify):*											27
28	**TOTAL General Administration**	86,922	6,278	311,034	404,234		404,234	142,766	547,000			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,252,501	204,925	1,104,062	2,561,488		2,561,488	124,310	2,685,798			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000. SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Jeffersonian Care Center #0039818 Report Period Beginning: 07/01/03 Ending: 06/30/04

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			8,084	8,084		8,084	75,311	83,395			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,697	6,697		6,697	165,619	172,316			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			260,553	260,553		260,553	(260,553)				34
35	Rent-Equipment & Vehicles			684	684		684		684			35
36	Other (specify):*											36
37	**TOTAL Ownership**			276,018	276,018		276,018	(19,623)	256,395			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		187,020	4,106	191,126		191,126		191,126			39
40	Barber and Beauty Shops			36	36		36		36			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			35,685	35,685		35,685		35,685			42
43	Other (specify):* Nonallowable Costs			57,908	57,908		57,908	(57,908)				43
44	**TOTAL Special Cost Centers**		187,020	97,735	284,755		284,755	(57,908)	226,847			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,252,501	391,945	1,477,815	3,122,261		3,122,261	46,779	3,169,040			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/03 Ending: 06/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,994	30		9
10	Interest and Other Investment Income	(400)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(8,212)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(9,846)	43		18
19	Entertainment				19
20	Contributions	(28)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,230)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(17,113)	43		24
25	Fund Raising, Advertising and Promotional	(962)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(307)	43		28
29	Other-Attach Schedule See Attached Schedule 5A	(29,936)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (65,040)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	111,819		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 111,819		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 46,779		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Jeffersonian Care Center
Provider #: 0039818
07/01/03 to 06/30/04 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference
JFR Xray Part A	(11,190)	43
JFR Lab Part A	(18,333)	43
JFR Lab Private/other	(129)	43
JFR Misc. Income	(284)	21
	(29,936)	

SEE ACCOUNTANTS' COMPILATION REPORT

Jeffersonian Care Center

ID# 0039818

Report Period Beginning: 07/01/03

Ending: 06/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jeffersonian Care Center # 0039818 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,230)	12,932	0	0	0	0	0	0	0	0	0	10,702	19
20	Fees, Subscriptions & Promotions	0	113	6	0	0	0	0	0	0	0	0	119	20
21	Clerical & General Office Expenses	0	2,482	0	0	0	0	0	0	0	0	0	2,482	21
22	Employee Benefits & Payroll Taxes	0	68,281	0	0	0	0	0	0	0	0	0	68,281	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	119	0	0	0	0	0	0	0	0	0	119	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	42,891	0	0	0	0	0	0	0	0	0	42,891	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(2,230)	126,818	6	0	0	0	0	0	0	0	0	124,594	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,230)	126,818	6	0	0	0	0	0	0	0	0	124,594	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Jeffersonian Care Center # 0039818 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,994	0	71,317	0	0	0	0	0	0	0	0	75,311	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,612)	1,734	172,497	0	0	0	0	0	0	0	0	165,619	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(260,553)	0	0	0	0	0	0	0	0	(260,553)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,618)	1,734	(16,739)	0	0	0	0	0	0	0	0	(19,623)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(28,256)	0	0	0	0	0	0	0	0	0	0	(28,256)	43
44	**TOTAL Special Cost Centers**	(28,256)	0	0	0	0	0	0	0	0	0	0	(28,256)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(35,104)	128,552	(16,733)	0	0	0	0	0	0	0	0	76,715	45

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Caravilla Residential Centers, Inc.	100%	Mt. Vernon Care Center	Mt. Vernon	Caravilla Charitable		
		Casey Care Center	Mt. Vernon	Corporation	Mt. Vernon	Lessor
Note: No board member provided services to the nursing home during the reporting period. No business entity owned by a board member conducted business transactions						
with the nursing home during the reporting period.						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	24	Board member travel	$	Caravilla Residential Centers, Inc.	100.00%	$ 119	$ 119	1
2	V	19	Professional fees		Caravilla Residential Centers, Inc.	100.00%	12,932	12,932	2
3	V	20	Licenses, dues & subscriptions		Caravilla Residential Centers, Inc.	100.00%	113	113	3
4	V	21	Office supplies & telephone		Caravilla Residential Centers, Inc.	100.00%	2,482	2,482	4
5	V	22	Emp. Benefits & payroll taxes		Caravilla Residential Centers, Inc.	100.00%	68,281	68,281	5
6	V	26	Vehicle, fire & liab. insurance		Caravilla Residential Centers, Inc.	100.00%	42,891	42,891	6
7	V	32	Interest expense		Caravilla Residential Centers, Inc.	100.00%	1,734	1,734	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 128,552	$ * 128,552	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Licenses, dues & subscriptions	$	Caravilla Charitable Corporation	**	$ 6	$ 6	15
16	V	30	Depreciation		Caravilla Charitable Corporation	**	71,317	71,317	16
17	V	32	Interest expense		Caravilla Charitable Corporation	**	172,497	172,497	17
18	V	34	Rent expense	260,553	Caravilla Charitable Corporation	**		(260,553)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V				**Caravilla Charitable Corporation and Caravilla				27
28	V				Residential Centers, Inc. have the same board of directors.				28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 260,553			$ 243,820	$ * (16,733)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Robert Bauer	President	Board Member	None	None	2 hrs/mtg.		None	$ 0		1
2	Roger Ryan	Vice President	Board Member	None	None	2 hrs/mtg.		None	0		2
3	William Armstrong	Treasurer	Board Member	None	None	2 hrs/mtg.		None	0		3
4	Kay Baker	Secretary	Board Member	None	None	2 hrs/mtg.		None	0		4
5	Ronald O'Daniell	Director	Board Member	None	None	2 hrs/mtg.		None	0		5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/03 Ending: 06/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Caravilla Residential Centers, Inc.
Street Address: 2020 W. War Memorial Dr., Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-9596

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	24	Board member travel	Number of beds	235	3	$ 430	$	65	$ 119	1
2	19	Professional fees	Number of beds	235	3	46,754		65	12,932	2
3	20	Licenses, dues & subscriptions	Number of beds	235	3	408		65	113	3
4	21	Office supplies & telephone	Number of beds	235	3	7,744		65	2,482	4
5	32	Interest expense	Number of beds	235	3	6,270		65	1,734	5
6										6
7										7
8										8
9										9
10	22	Emp. benefits & payroll taxes	Direct method						68,281	10
11	26	Vehicle, fire & liab. insurance	Direct method						42,891	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 61,606	$		$ 128,552	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/03 Ending: 06/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	NCS Healthcare, Inc.		X	Hardware/software	$728.00	10/31/98	$ 29,136	$ 5,781	09/30/04	0.1429	$	1
2	Continental Wingate		X	Purchase of facility	$55,560.00	09/19/96	7,402,500	1,984,604	10/01/31	0.0855	169,684	2
3												3
4												4
5								Amortization expense			2,632	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$56,288.00		$ 7,431,636	$ 1,990,385			$ 172,316	9
	B. Non-Facility Related*											
10							Finance charges				8,431	10
11							Nonallowable interest expense				(8,212)	11
12							Offset interest income				(400)	12
13							Parent company allocation				181	13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 7,431,636	$ 1,990,385			$ 172,316	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/03 Ending: 06/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	N/A	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Jeffersonian Care Center COUNTY Jefferson

FACILITY IDPH LICENSE NUMBER 0039818

CONTACT PERSON REGARDING THIS REPORT Allan Herrmann

TELEPHONE (309) 685-0595 FAX #: (309) 685-9596

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.	N/A		$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/03 Ending: 06/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,008 B. General Construction Type: Exterior Brick Frame Block Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	125,030	1994	$ 50,000	1
2					2
3	TOTALS	125,030		$ 50,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	65		1994	1965	$ 1,259,750	$	40	$ 31,494	$ 31,494	$ 307,066	4
5			1998	1998	9,815		40	245	245	1,593	5
6			1999	1999	1,026		40	26	26	143	6
7											7
8											8
	Improvement Type**										
9	Tile			1995	847		15	56	56	476	9
10	Fire Alarm			1996	10,125		15	675	675	4,978	10
11	Asphalt Resurfacing			1996	14,059		15	937	937	6,910	11
12	Architecture Costs			1996	4,869		15	325	325	2,397	12
13	Heating Installation			1996	14,278		15	952	952	7,021	13
14	Flooring			1997	10,440		15	696	696	5,133	14
15	Plumbing			1997	20,029		15	1,335	1,335	9,846	15
16	Rubberized Base Board Installation			1997	3,637		15	242	242	1,785	16
17	Fire Alarm			1997	1,350		15	90	90	664	17
18	Architecture Costs			1997	1,217		15	81	81	597	18
19	Roofing			1997	15,880		15	1,059	1,059	7,810	19
20	Heating and Air Conditioning			1997	3,762		15	251	251	1,851	20
21	Windows and Patio Door Installation			1997	27,742		15	1,849	1,849	13,639	21
22	Remodeling of facility			1997	4,208		15	281	281	1,826	22
23	Shutters and Windows			1997	2,350		15	157	157	1,020	23
24	Roofing			1997	153		15	10	10	65	24
25	Replace Controls			1998	2,516		15	168	168	1,092	25
26	Flooring			1998	27,771		15	1,851	1,851	12,031	26
27	Electrical Service/Plumbing			1998	1,063		15	71	71	461	27
28	Remodeling of facility			1998	1,229		15	82	82	533	28
29	Electrical/Light Fixtures			1998	2,834		15	189	189	1,229	29
30	Security Control Panel			1998	665		15	44	44	286	30
31	Air Conditioners			1998	1,316		15	88	88	572	31
32	Architects Fees & Site Plan			1998	7,058		15	471	471	2,590	32
33	Landscaping			1998	1,789		15	119	119	655	33
34	Emergency Roof Repair			1999	4,600		15	307	307	1,688	34
35	Ceiling & Lighting			1999	1,777		15	118	118	649	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Painting and remodeling	1999	$ 11,749	$	15	$ 783	$ 783	$ 3,506	37
38	Tile	2000	1,404		15	94	94	329	38
39	Labor for building improvements	2000	14,189		15	946	946	3,784	39
40	Automatic transfer switch	2002	3,028		15	202	202	505	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,488,525	$		$ 46,294	$ 46,294	$ 404,730	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 377,621	$ 6,681	$ 35,993	$ 29,312	5-10 years	$ 282,468	71
72	Current Year Purchases	6,380	319	319		5-10 years	319	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 384,001	$ 7,000	$ 36,312	$ 29,312		$ 282,787	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident use	1997 Ford E150***	1997	$ 13,243	$	$	$	3	$ 13,243	76
77	Resident use	1998 Chevy Corsica***	2002	489	163	163		3	408	77
78	Resident use	1997 Ford Taurus***	2002	978	326	326		3	815	78
79	Resident use	1992 Chevy Van***	2002	900	300	300		3	750	79
80	TOTALS			$ 15,610	$ 789	$ 789	$		$ 15,216	80

*** Cost allocated between 3 facilities

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,938,136	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 7,789	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 83,395	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 75,606	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 702,733	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/03 Ending: 06/30/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A . N/A

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 684 Description: Postage Meter $672, Dish washer $12
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 1,414	$	$ 1,414
2	Books and Supplies		242		242
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		200		200
9	TOTALS	$	$ 1,856	$	$ 1,856
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,856			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	5

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	4,692	$ 304,991	$	4,692	$ 304,991	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		914	70,380		914	70,380	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		4,716	306,429		4,716	306,429	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				187,020		187,020	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Special Services	L39, C3					4,106		4,106	13
14	TOTAL			$	10,322	$ 681,800	$ 191,126	10,322	$ 872,926	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/03 Ending: 06/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 63,651	$ 63,651	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 568,340)	300,454	300,454	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,935	22,935	6
7	Other Prepaid Expenses	942	942	7
8	Accounts Receivable (owners or related parties)	1,068,467	1,068,467	8
9	Other(specify): See attached schedule 17A	10,928	10,928	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,467,377	$ 1,467,377	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost		1,270,591	14
15	Leasehold Improvements, at Historical Cost	4,432	217,934	15
16	Equipment, at Historical Cost	73,394	399,611	16
17	Accumulated Depreciation (book methods)	(38,442)	(702,733)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Investment in subsidiary	1,524	1,524	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 40,908	$ 1,236,927	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,508,285	$ 2,704,304	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 491,633	$ 491,633	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	76,407	76,407	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached schedule 17A	1,825,256	924,176	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,393,296	$ 1,492,216	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,781	1,990,385	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,781	$ 1,990,385	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,399,077	$ 3,482,601	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (890,792)	$ (778,297)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,508,285	$ 2,704,304	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Jeffersonian Care Center
Provider #0039818
June 30, 2004 **Schedule 17A**

Schedule XV. Balance Sheet

Line 9 - Other Current Assets	Operating	After Consolidation
Prepaid Deposit	6,436	6,436
Medicare Settlement	4,492	4,492
	10,928	10,928

Line 36 - Other Current Liabilities		
Accrued Expense	3,130	3,130
Resident Credit Balances	10,471	10,471
Due to Related Parties	982,429	982,429
Accrued Rent	792,516	(108,564)
Accrued Participation Fees	26,716	26,716
Accrued Insurance Payable	9,994	9,994
	1,825,256	924,176

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (856,293)	1
2	Restatements (describe):		2
3	**Prior Period Audit Adjustments**	22,820	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (833,473)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	71,233	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Certain expense allocations**		15
16	Other (describe) **added back in column 7**	(128,552)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (57,319)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (890,792)	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,059,280	1
2	Discounts and Allowances for all Levels	(570,834)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,488,446	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,375,811	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,375,811	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	590	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	279,494	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,911	19
20	Radiology and X-Ray	10,331	20
21	Other Medical Services	11,322	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 326,648	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	397	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 397	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**See attached schedule 19a**	2,192	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,192	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,193,494	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	433,893	31
32	Health Care	1,723,361	32
33	General Administration	404,234	33
	B. Capital Expense		
34	Ownership	276,018	34
	C. Ancillary Expense		
35	Special Cost Centers	249,070	35
36	Provider Participation Fee	35,685	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,122,261	40
41	**Income before Income Taxes (line 30 minus line 40)****	71,233	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 71,233	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. A federal tax return is filed for the combined divisions of Caravilla Residential Centers, Inc.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Jeffersonian Care Center
Provider #0039818
June 30, 2004 **Schedule 19A**

XVII. Income Statement
Line 28: Other

Description	Amount
Vending Income	1,908
Miscellaneous Income	284
Total	2,192

See Accountants' Compilation Report

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,962	2,036	$ 39,583	$ 19.44	1
2	Assistant Director of Nursing	1,976	2,096	38,592	18.41	2
3	Registered Nurses	7,200	7,773	121,212	15.59	3
4	Licensed Practical Nurses	16,969	18,126	244,689	13.50	4
5	Nurse Aides & Orderlies	44,220	46,673	362,339	7.76	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,793	4,086	34,206	8.37	8
9	Activity Director					9
10	Activity Assistants	2,840	2,946	21,307	7.23	10
11	Social Service Workers	2,358	2,549	20,344	7.98	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,840	15,920	104,755	6.58	15
16	Dishwashers					16
17	Maintenance Workers	1,891	2,072	19,973	9.64	17
18	Housekeepers	9,850	10,775	67,192	6.24	18
19	Laundry	3,995	4,321	25,112	5.81	19
20	Administrator	1,980	2,039	47,333	23.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,756	4,082	39,589	9.70	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,110	1,135	8,465	7.46	31
32	Other Health Ca See Sch 20A	3,892	4,194	57,810	13.78	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	122,632	130,823	$ 1,252,501 *	$ 9.57	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	128	$ 6,180	L1, C3	35
36	Medical Director	monthly	6,100	L9, C3	36
37	Medical Records Consultant	39	1,635	L10, C3	37
38	Nurse Consultant	monthly	1,030	L10, C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	16	128	L10A, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	42	2,378	L11, C3	44
45	Social Service Consultant	42	2,378	L12, C3	45
46	Other(specify) Office Consultant	monthly	332	L21, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	267	$ 20,161		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Jeffersonian Care Center
Provider #0039818
June 30, 2004 **Schedule 20A**

Schedule XVIII. A. Staffing and Salary Costs
Line 32 - Other Health Care

Title	Hours Worked	Hours Paid	Salaries	Average Hourly Wage
Care Plan Coordinator	3,335	3,616	53,469	14.79
Ancillary Clerk	557	578	4,341	7.51
	3,892	4,194	57,810	13.78

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan Morgan	Administrator	0	$ 15,333
Debbi Jackson	Administrator	0	32,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 47,333

B. Administrative - Other

Description	Amount
Developmental Services of Illinois, Inc. -	$
Administrative Service Fees	144,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 144,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	U/C Consulting	$ 1,020
Campbell, Black, Carnine,		
Hedin, Ballard & McDonald	Legal	2,230
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 3,250

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 66,187
Unemployment Compensation Insurance	15,337
FICA Taxes	94,706
Employee Health Insurance	15,205
Employee Meals	18,456
Illinois Municipal Retirement Fund (IMRF)*	
Employee Morale	3,202
TOTAL (agree to Schedule V, line 22, col.8)	$ 213,093

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 750
Advertising: Employee Recruitment	865
Health Care Worker Background Check	
(Indicate # of checks performed 90)	630
IHCA Dues	3,218
Various Fees	292
Expense Allocations	6
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,761

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	590
Seminar Expense	6,329
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,919

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Jeffersonian Care Center
Provider #: 0039818
07/01/03 to 06/30/04

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services		Type	Amount
Total (agree to Schedule V, line 19, column 3)			3,250
Allocated from Caravilla Residential Centers, Inc.			
	American Express Tax & Business Services	Accounting	277
	Altschuler, Melvoin & Glasser LLP	Accounting	12,655
Less: non-allowable collectic	Campbell, Black, Carnine, Hedin, Ballard, & McDonald	Legal	(2,230)
Total (agree to Schedule V, line 19, column 8)			13,952

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4								N/A					
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/03 Ending: 06/30/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association $3,218**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **No**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **2,641** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **35,685**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **18,456** Has any meal income been offset against
related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **61%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Altschuler, Melvoin, and Glasser LLP** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Audit is currently in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	104,755	8,192	6,180	119,127	0	119,127	0	119,127
2. Food Purchase	0	96,918	0	96,918	0	96,918	-18,456	78,462
3. Housekeeping	67,192	10,481	0	77,673	0	77,673	0	77,673
4. Laundry	25,112	7,485	0	32,597	0	32,597	0	32,597
5. Heat and Other Utilities	0	0	65,085	65,085	0	65,085	0	65,085
6. Maintenance	19,973	0	22,520	42,493	0	42,493	0	42,493
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	217,032	123,076	93,785	433,893	0	433,893	-18,456	415,437
9. Medical Director	0	0	6,100	6,100	0	6,100	0	6,100
10. Nursing & Medical Records	906,896	73,529	2,665	983,090	0	983,090	0	983,090
10a. Therapy	0	0	681,928	681,928	0	681,928	0	681,928
11. Activities	21,307	1,977	3,437	26,721	0	26,721	0	26,721
12. Social Services	20,344	65	2,378	22,787	0	22,787	0	22,787
13. Nurse Aide Training	0	0	1,856	1,856	0	1,856	0	1,856
14. Program Transportation	0	0	879	879	0	879	0	879
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	948,547	75,571	699,243	1,723,361	0	1,723,361	0	1,723,361
17. Administrative	47,333	0	144,000	191,333	0	191,333	0	191,333
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	3,250	3,250	0	3,250	10,702	13,952
20. Fees, Subscriptions & Promotion	0	0	5,642	5,642	0	5,642	119	5,761
21. Clerical & General Office	39,589	6,278	23,683	69,550	0	69,550	2,198	71,748
22. Employee Benefits & Payroll	0	0	126,356	126,356	0	126,356	86,737	213,093
23. Inservice Training & Education	0	0	759	759	0	759	0	759
24. Travel and Seminar	0	0	6,800	6,800	0	6,800	119	6,919
25. Other Admin. Staff Trans	0	0	544	544	0	544	0	544
26. Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	42,891	42,891
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	86,922	6,278	311,034	404,234	0	404,234	142,766	547,000
29. Total General Administrative	1,252,501	204,925	1,104,062	2,561,488	0	2,561,488	124,310	2,685,798
30. Depreciation	0	0	8,084	8,084	0	8,084	75,311	83,395
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	6,697	6,697	0	6,697	165,619	172,316
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	260,553	260,553	0	260,553	-260,553	0
35. Rent - Equipment & Vehicles	0	0	684	684	0	684	0	684
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	276,018	276,018	0	276,018	-19,623	256,395
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	187,020	4,106	191,126	0	191,126	0	191,126
40. Barber and Beauty Shop	0	0	36	36	0	36	0	36
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Provider Participation	0	0	35,685	35,685	0	35,685	0	35,685
43. Other (specify):*	0	0	57,908	57,908	0	57,908	-57,908	0
44. Total Special Cost Ce	0	187,020	97,735	284,755	0	284,755	-57,908	226,847
45. Grand Total	1,252,501	391,945	1,477,815	3,122,261	0	3,122,261	46,779	3,169,040

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	63,651	63,651
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	300,454	300,454
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	22,935	22,935
7. Other Prepaid Expenses	942	942
8. Accounts Receivable-Owner/Related Party	1,068,467	1,068,467
9. Other (specify):	10,928	10,928
10. Total current assets	1,467,377	1,467,377
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	50,000
14. Buildings, at Historical Cost	0	1,270,591
15. Leasehold Improvements, Historical Cost	4,432	217,934
16. Equipment, at Historical Cost	73,394	399,611
17. Accumulated Depreciation (book methods)	-38,442	-702,733
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	1,524	1,524
24. Total Long-Term Assets	40,908	1,236,927
25. Total Assets	1,508,285	2,704,304
CURRENT LIABILITIES		
26. Accounts Payable	491,633	491,633
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	76,407	76,407
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	1,825,256	924,176
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	2,393,296	1,492,216
LONG TERM LIABILITES		
39.Long-Term Notes Payable	5,781	1,990,385
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	5,781	1,990,385
46.Total Liabilities	2,399,077	3,482,601
47.Total Equity	-890,792	-778,297
48.Total Liabilities and Equity	1,508,285	2,704,304

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,059,280
2. Discounts and Allowances for all Levels	-570,834
Subtotal - Inpatient Care	1,488,446
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	1,375,811
7. Oxygen	0
Subtotal - Anciliary Revenue	1,375,811
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	590
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	279,494
18. Sale of Supplies to Non-Patients	0
19. Laboratory	24,911
20. Radiologyand X-Ray	10,331
21. Other Medical Services	11,322
22. Laundry	0
Subtotal - Other Operating Revenue	326,648
24. Contributions	0
25. Interest and Other Investments Income	397
Subtotal - Non-Operating Revenue	397
27. Other Revenue (specify):	0
28. Other Revenue (specify):	2,192
Subtotal - Other Revenue	2,192
30. Total Revenue	3,193,494
31. General Services	433,893
32. Health Care	1,723,361
33. General Administration	404,234
34. Ownership	276,018
35. Special Cost Centers	249,070
35. Provider Participation Fee	35,685
37. Other	0
40. Total Expenses	3,122,261
41. Income Before Income Taxes	71,233
42. Income Taxes	0
43. Net Income or Loss for the Year	71,233

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